**BEFORE THE**
**MEDICAL BOARD OF CALIFORNIA**
**DEPARTMENT OF CONSUMER AFFAIRS**
**STATE OF CALIFORNIA**

| | | |
|---|---|---|
| **In the Matter of the Accusation Against:** | ) | |
| | ) | |
| | ) | |
| **WILLIAM S. EIDELMAN, M.D.** | ) | **File No. 800-2014-010147** |
| | ) | |
| **Physician's and Surgeon's Certificate No.** | ) | |
| | ) | |
| **Respondent.** | ) | |
| | ) | |

## DECISION EFFECTIVE DATE AFTER JUDICIAL REVIEW

On December 6, 2018, the Medical Board of California issued its Decision in the Matter of the Accusation against William S. Eidelman, M.D. with an effective date of January 4, 2019.

On January 3, 2019, respondent filed a Verified Petition for Writ of Administrative Mandamus and Ex Parte Motion for Order to Stay Decision and License Revocation Order in the Superior Court of the State of California for the County of San Francisco, Case No. CPF-19-516480. On January 29, 2019, the Superior Court issued an Order Granting Temporary Stay, wherein the Medical Board's Decision was stayed until further order of the court.

On April 2, 2019, the Superior Court issued a Judgment Denying Petition for Writ of Administrative Mandate. Since no additional Stays have been granted by any higher Court, the Stay, issued on January 29, 2019, was dissolved and the **Decision became effective April 2, 2019.**

ORIGINAL

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SUPERIOR COURT OF THE STATE OF CALIFORNIA

COUNTY OF SAN FRANCISCO

**WILLIAM S. EIDELMAN, M.D.,**

Petitioner,

**v.**

**MEDICAL BOARD OF CALIFORNIA,**

Respondent.

Case No. CPF-19-516480

**[Proposed] JUDGMENT DENYING PETITION FOR WRIT OF ADMINISTRATIVE MANDATE**

**Hearing: March 12, 2019, 9:30 a.m.**
**Location: Dept. 302**
**Action Filed: January 3, 2019**



This matter came before this Court on March 12, 2019, for hearing on the petition for writ of administrative mandate filed by Petitioner, William S. Eidelman, M.D. Petitioner was represented by the ADLI Law Group, P.C., by Anthony K. McClaren, Esq. Xavier Becerra, Attorney General, by Edward Kim, Deputy Attorney General, appeared as attorneys for respondent Medical Board of California.

The Court, having read and considered all pleadings and documents on file in this action, having heard oral argument, having exercised its independent judgment, and having issued its Order Denying Petition for Writ of Administrative Mandate, dated March 12, 2019, which is attached hereto as Exhibit A and shall serve as the Statement of Decision under Code of Civil Procedure section 632, hereby denies the petition for writ of administrative mandate.

///

The Court, therefore, ORDERS, ADJUDGES AND DECREES, that:

1. The petition filed in this action for a writ of administrative mandate is denied;

2. Petitioner shall take nothing by this action, and,

3. Respondent Medical Board of California shall recover costs in this proceeding in the amount of $ TBD.

Dated: March 27, 2019

Judge of the Superior Court
ETHAN P. SCHULMAN

SEE EXHIBIT "A" RE
COMPLIANCE WITH CRC 3.1312

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Exhibit A

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SUPERIOR COURT OF THE STATE OF CALIFORNIA

COUNTY OF SAN FRANCISCO

| | |
|---|---|
| **WILLIAM S. EIDELMAN, M.D.,** Petitioner, **v.** **MEDICAL BOARD OF CALIFORNIA,** Respondent. | Case No. CPF-19-516480 **~~[Proposed]~~ ORDER DENYING PETITION FOR WRIT OF ADMINISTRATIVE MANDATE** **Hearing: March 12, 2019, 9:30 a.m.** **Location: Dept. 302** |

This matter came before this Court on March 12, 2019, for hearing on the petition for writ of administrative mandate filed by Petitioner, William S. Eidelman, M.D. Petitioner was represented by the ADLI Law Group, P.C., by Anthony K. McClaren, Esq. Xavier Becerra, Attorney General, by Edward Kim, Deputy Attorney General, appeared as attorneys for respondent Medical Board of California.

The Court, having read and considered all pleadings and documents on file in this action, having heard oral argument, and having exercised its independent judgment, hereby ORDERS as follows:

Petitioner's petition for writ of administrative mandamus is denied. In making this decision, the Court has considered all of the papers filed and lodged with the Court. The Court will refer to the actual pages of the reporter's transcript ("RT") rather than the Bates-stamped pages attached to the petition. The Court will also refer to the actual pages of the ALJ's Decision.

Jennifer Burkhart's e-mail package that was forwarded to respondent constitutes a

"complaint" within the meaning of 16 CCR § 1356.2(b)(1). A proper "complaint" under the regulation is simply "a written complaint from the public...that names a particular physician." Nothing more is required. There is no authority that the complaint needed to be submitted on a particular type of form. Business and Professions Code § 800(b)(1) merely provides that respondent shall promulgate forms that members of the public may use to report misconduct. Those forms are not the exclusive means to report wrongdoing and adopting petitioner's argument would seriously undermine public safety.

The court rejects petitioner's argument, raised for the first time in the reply, that respondent proceeded in excess of its jurisdiction because Eric Ryan forwarded Ms. Burkhart's e-mail package to respondent rather than informing Ms. Burkhart to contact the respondent herself. (See Civ. Code § 43.96(a).) The Court does not consider arguments raised for the first time in the reply because of due process concerns. In any event, there is no cited authority holding that Mr. Ryan's purported failure to comply with the Civil Code would have any effect on respondent's power to conduct investigations and file accusations.

Respondent's accusation was not time-barred. Business and Professions Code § 10101 is an inapposite statute of limitations that pertains to real estate licenses. Petitioner's reply concedes that the governing statute of limitations is found in Business and Professions Code § 2230.5(a). Under that provision, the accusation needed to be filed "within three years after the board" discovered the alleged wrongdoing. In this case, the respondent board discovered the alleged negligence on November 25, 2014, when Eric Ryan forwarded the information to respondent. Respondent subsequently filed a timely accusation on November 22, 2017. (RT, 19:19; 20:13-14.)

Eric Ryan's receipt of the information on November 14, 2014 did not give respondent notice to trigger the statute of limitations. "Each of the boards comprising the department [of consumer affairs] exists as a separate unit..." (Bus. & Prof. Code § 108; see also *Greyhound Lines, Inc. v. Cal. Highway Patrol* (2013) 213 Cal.App.4th 1129, 1134 [CHP and Caltrans have separate identities even though they are both part of the same agency]; (*People ex rel. Lockyer v. Superior Court* (2004) 122 Cal.App.4th 1060, 1078 ["Each agency or department of the state is

established as a separate entity, under various state laws or constitutional provisions."].) When Eric Ryan received the e-mail from Burkhart, he worked for the Health Quality Investigation Unit. He did not work for respondent. Ryan's unit is a subdivision of the Department of Consumer Affairs Investigation Division. (RT, 22:2-24.) The Health Quality Investigation Unit serves respondent as well as other boards. (See Bus. & Prof. Code §§ 159.5(b)(1), 160.5(b).) Therefore, the ALJ's determination that respondent did not receive the complaint when Eric Ryan received it was correct.

Petitioner's reply attacks the testimony of Kenneth Buscarino, which shows that respondent no longer employed Mr. Ryan when the e-mail package was delivered. (RT, 22:2-24.) Since Mr. Buscarino and Ryan worked in the same position, he was competent to testify regarding who employed them. The Court further notes that petitioner does not highlight any evidence showing that Mr. Ryan can be considered respondent's agent for purposes of notice. As far as the Court can discern, the only evidence before the ALJ was Buscarino's testimony and it was petitioner's burden to establish the statute of limitations defense. (Decision at 20, citing Evid. Code §§ 115, 500; see *Bohn v. Watson* (1954) 130 Cal.App.2d 24, 36 [in administrative proceedings, "[i]t is well established that the statute of limitations is a personal privilege which is waived unless asserted at the proper time and in the proper manner..."].)

The weight of the evidence supports respondent's findings. "[I]n exercising its independent judgment, a trial court must afford a strong presumption of correctness concerning the administrative findings, and the party challenging the administrative decision bears the burden of convincing the court that the administrative findings are contrary to the weight of the evidence." (*Fukuda v. City of Angels* (1999) 20 Cal.4th 805, 817.)

Here, respondent's expert (Dr. Raiss) persuasively testified that petitioner's cursory examination of 20-30 minutes was grossly negligent and violated the standard of care. (RT, 95:8-96:18; 98:1-7; 100:20-101:14; 115:12-117:5; 187:7). Dr. Raiss stated that a meeting of at least an hour is usually necessary and petitioner did not sufficiently review T.T's medical history, prior treatment, developmental history, etc. He further explained that petitioner should have reviewed the diagnostic criteria in the DSM (Diagnostic and Statistical Manual of Mental Disorders). (RT,

102:24-104:14.) There is no evidence that that ever occurred. Petitioner also seemed to fail to realize that a diagnosis of bipolar disorder in a 5-year old is extremely rare. (RT, 180:4-24; RT II, 98:12-99:6.) Petitioner was ignorant of the diagnostic criteria and admitted that he largely relied on family history to make his diagnosis. (RT, 139:1-3; RT III, 205:7-9; Interview, 21:12-14.) Family history is only one factor, however. (RT, 96:3-11.) Dr. Briggs believed that there should have been a referral to a specialist to determine the existence of bipolar disorder. (RT II, 108:1-24.)

Respondent did not violate the safe harbor of Business and Professions Code § 2234.1. Petitioner was not disciplined for rendering treatment constituting alternative or complementary medicine to T.T., much "solely" for doing so. Rather, respondent revoked his license because petitioner was grossly negligent in his diagnosis of a minor patient without an adequate basis or adequate research and study, as well as in basing care and treatment on that diagnosis; for repeated negligent acts (three erroneous diagnoses); for incompetence due to his ignorance of the diagnostic criteria and failure to recommend assessment of the patient by a qualified specialist; and for general unprofessional conduct. (Decision, pgs. 23-25.)

Petitioner fails to show that the penalty was excessive. Petitioner bears the heavy burden of showing that the penalty was arbitrary. (See *Cadilla v. Board of Medical Examiners* (1972) 26 Cal.App.3d 961, 966.) Here, respondent's decision was reasonable given that petitioner had been placed on probation on two prior occasions and exhibited little remorse. (Decision, pg. 25; RT III 218:4-7; 220:15-22; 224:14-16.)

Lastly, the Court rejects petitioner's new reply argument that he did not receive a fair trial because the ALJ was biased and a "de facto agent" of respondent. (Reply, 14:8.) The moving papers do not develop any of these issues and as stated, new reply arguments are improper. √d

Dated: March 12, 2019

Judge of the Superior Court

ETHAN P. SCHULMAN

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*XAVIER BECERRA*
*Attorney General*

*State of California*
***DEPARTMENT OF JUSTICE***

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March 18, 2019

Court Clerk to the Honorable Ethan P. Schulman
San Francisco County Superior Court
400 McAllister St,
Department 302
San Francisco, CA 94102

Re: TRANSMITTAL OF PROPOSED JUDGMENT
*WILLIAM S. EIDELMAN, M.D. v. MEDICAL BOARD OF CALIFORNIA,*
Superior Court of California, County of San Francisco, Case No. CPF-19-516480

Dear Clerk:

Pursuant to the ruling of the Superior Court in this matter, which denied the petition for writ of mandate, the Medical Board of California files the enclosed Proposed Judgment Denying Petition for Writ of Administrative Mandate, which has previously been mailed to Petitioner's attorney without response for five days.

Please mark the enclosed copy of this document as "received" and return it in the enclosed self-addressed stamped envelope to my attention. We appreciate your professional courtesy in this matter. Please do not hesitate to call me if you have any questions.

Sincerely,

E. A. Jones III
Supervising Deputy Attorney General

For XAVIER BECERRA
Attorney General

EKK:mcg
cc: Anthony K. McClaren, Esq.

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B

EXHIBIT "A"

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Attorneys for Petitioner, WILLIAM S. EIDELMAN, M.D.

**SUPERIOR COURT OF CALIFORNIA,**
**COUNTY OF SAN FRANCISCO**

| | |
|---|---|
| WILLIAM S. EIDELMAN, M.D.<br>Petitioner,<br>vs.<br>MEDICAL BOARD OF CALIFORNIA,<br>Respondent. | CASE NO: CPF-19-516480<br><br>[PROPOSED] ORDER GRANTING TEMPORARY STAY<br><br>Date: January 4, 2019<br>Time: 11:00 a.m.<br>Judge: Hon. Harold Kahn<br>Dept.: 302 |

Good cause appearing, and after consideration of the oral arguments and the pleadings on file herein, the Ex Parte Application for Temporary Stay of Petitioner William S. Eidelman, M.D. ("Dr. Eidelman") is **GRANTED AS FOLLOWS:**

**IT IS ORDERED:**

1. The Decision dated December 6, 2018, which would have been become effective at 5:00 p.m. on January 4, 2019, denominated *In the Matter of the Accusation against WILLIAM S. EIDELMAN, M.D.*, MBC Case No. 8002014010147, OAH No. 2018030645 S is hereby enjoined from

further effect;

2. Dr. Eidelman shall not treat patients under 18 years of age. Dr. Eidelman shall not make or issue any recommendations for cannabis or cannabis treatment for any juvenile patients under the age of eighteen (18). The ban on medical treatment of patients under 18 years of age is in effect pending the resolution of this proceeding or until the termination of the stay, upon further order of the court, or upon agreement by the parties;
3. Dr. Eidelman shall not make or issue any recommendation for cannabis or cannabis treatment for any adult patients without obtaining a medical history and conducting a medical examination of the adult patient;
4. The Court sets the following briefing schedule:
    - Petitioner shall file and serve supplemental opening brief by February 6 2019;
    - Respondent shall file and serve supplemental opposition brief by February 27, 2019; and
    - Petitioner shall file and serve its reply brief by March 6, 2019
5. Hearing set for March 12, 2019 at 9:30 a.m., Department 302.

The Temporary Stay shall remain in effect until further Order of the Court. **IT IS SO ORDERED.**

**The parties stipulate that this is a true and correct memorialization of the courts ruling of January 4, 2019.**

Dated: 1-28-2019

By: _____
Rebecca Wagner, Dep. Attorney General

Dated: 1-28-2019

By: _____
Jennie Stepanian for Allison Margolin

Dated: 1/28/19

By: _____
Judge, Superior Court of California
Hon. Harold Kahn

**BEFORE THE**
**MEDICAL BOARD OF CALIFORNIA**
**DEPARTMENT OF CONSUMER AFFAIRS**
**STATE OF CALIFORNIA**

| | |
|---|---|
| **In the Matter of the Accusation Against:** | |
| **WILLIAM S. EIDELMAN, M.D.** | **Case No. 8002014010147** |
| | OAH No. 2018030645 |
| **Physician's and Surgeon's Certificate No. G32011** | |
| **Respondent** | |

## DECISION

**The attached Proposed Decision is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.**

**This Decision shall become effective at 5:00 p.m. on January 4, 2019.**

**IT IS SO ORDERED December 6, 2018.**

**MEDICAL BOARD OF CALIFORNIA**

**By:** _____
**Ronald H. Lewis, MD, Chair**
**Panel A**

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

| | |
|---|---|
| In the Matter of the Accusation Against:<br><br>WILLIAM S. EIDELMAN, M.D.,<br><br>Physician's and Surgeon's Certificate No. G 32011,<br><br>Respondent. | Case No. 800-2014-010147<br><br>OAH No. 2018030645 |

# PROPOSED DECISION

The hearing in this matter took place at Los Angeles, California on July 11 through 13, 2018, before Joseph D. Montoya, Administrative Law Judge (ALJ), Office of Administrative Hearings.

Complainant Kimberly Kirchmeyer, Executive Director of the Medical Board of California (Board), was represented by Beneth A. Browne, Deputy Attorney General.

Respondent William S. Eidelman, M.D., appeared at the hearing and was represented by Richard Jaffe.

The parties agreed to file closing briefs, and reply briefs, and the record was therefore held open for that purpose. Each party's opening brief was to be submitted by September 7, 2018, and reply briefs were due on September 14, 2018. On September 6, 2018, the parties submitted a joint request to extend the deadlines by one week, so that opening briefs would be due on September 14, and reply briefs would be due by September 21. That request was granted.

On September 14, 2018, Respondent filed his written closing argument, with appendices and with Respondent's personal addendum. Those documents are collectively identified as exhibit 48.

On September 17, 2018, Complainant's closing argument was received, without objection, and it is marked as exhibit 49.

On September 18, 2018, Complainant submitted a request to extend the deadline to file reply papers, to which Respondent had no objection. Because Complainant's counsel had medical issues, the deadline was extended to October 10, 2018.

On October 5, 2018, each party submitted a reply brief. Complainant's is marked for identification as exhibit 50, and Respondent's is marked as exhibit 51.

The Accusation against Respondent identified the child patient, and his father, by random initials, instead of by their actual initials. However, they were at times referred to during the hearing by their names or initials, the court reporter being instructed to use initials in transcripts. Their real initials or status are used in this Proposed Decision, i.e., L.T. or father for the parent of the child patient, and T.T. or the child for the young patient.

By a separate protective order, a number of documents shall be sealed, as they reference the patient and parent by name, and it was impractical to redact the names from the documents.

The matter was submitted for decision on October 5, 2018.

The ALJ hereby makes his factual findings, legal conclusions, and order.

## SUMMARY OF THE CASE

Respondent is a physician who labels himself as a consultant in alternative medicine. A substantial amount of his practice involves providing medical marijuana recommendations to patients. In September 2012, one of his a patients, L.T., brought the patient's then five-year-old son (T.T) to Respondent for an examination and a medical marijuana recommendation. The child's father had obtained such recommendations from Respondent for himself and an older child in years prior, due to the father and older sibling carrying a diagnosis of Bipolar Disorder and Attention Deficit Hyperactivity Disorder, or ADHD.

The father told Respondent that the boy had had episodes of uncontrollable behavior and temper tantrums, and that this was causing trouble in school. Respondent met with father and son for 20 to 30 minutes, and no tantrums or unusual behavior was observed. Respondent diagnosed the boy as having a "probable combination" of ADHD and Bipolar Disorder. He then recommended that the boy be given small quantities of cannabis in cookies.

The child was given cannabis by his father, and his father reported improvements in the child's behavior to Respondent soon after the initial visit. Thereafter, the boy's school became aware that the child was being given cannabis, which then triggered an investigation by child protective services and law enforcement. That led to a referral to the Board.

Complainant asserts that Respondent committed gross negligence, repeated negligent acts, and demonstrated incompetence and general unprofessional conduct in his diagnosis and his cannabis recommendation. She also asserts that his medical records for this patient were inadequate.

Respondent asserts that his diagnosis was sound, and that cannabis is appropriate as a response to the diagnosed condition. He also asserted that the applicable statute of limitations had run, and that he should be immune from discipline under the Compassionate Use Act.

## FACTUAL FINDINGS

*The Parties and Jurisdiction*

1. Complainant brought and maintained the Accusation while acting in her official capacity.

2. On July 1, 1976, the Board issued Physician's and Surgeon's Certificate number G 32011 to Respondent. At the times relevant to this matter, it was valid. The Certificate is due to expire on February 28, 2019.

3. Respondent graduated from St. Louis University Medical School in 1975. He spent approximately one and one-half years in a combined internship/residency program in psychiatry; that was approximately one-half of the program's duration. He was then a general practitioner for approximately five years. In the 1980's he became interested in alternative medicine, and practiced it. In 1990 he was introduced to nutritional medicine, now known as functional medicine. In 1997, following passage of the Compassionate Use Act, he began providing medical marijuana recommendations. Although he still practices functional medicine, and he uses other treatment modalities, much of his practice is provision of medical marijuana recommendations.

4. Respondent's certificate was previously disciplined, as described hereafter.

5. The Accusation was filed on November 22, 2017. (Ex. 1, p. 1.) After it was served on Respondent he filed a timely Notice of Defense, requesting a hearing. This proceeding ensued. All jurisdictional requirements have been met.

*Respondent's Admissions*

6. Near the outset of the hearing, Respondent admitted that a number of the allegations in the Accusation were true. The admissions pertain to allegations found in paragraphs 9, 10, 11, and part of 12, with an exception to one sentence in paragraph 10.

Thus, Respondent admits the following, including the statements in the footnotes that are tied to the aforementioned paragraphs of the Accusation[1]:

> 9. On or about September 13, 2012, Respondent[2] had an appointment with a four-year-old boy, A.A.[3] During the appointment, the boy and his father, L.T.S. were in the room. Respondent talked with each of them at various times . . . . Respondent had treated L.T.S. in the past and provided him recommendations for marijuana for medical purposes. The chief complaint for the child was that he had episodes of uncontrollable behavior and temper tantrums. Respondent primarily spoke with L.T.S. during the appointment. Respondent noted that the boy was normal appearing, agitated from the stress of the day in school, coming to the doctor, alert, oriented, appropriate, but agitated, and having trouble sitting still. No looseness of association was noted. He was not talkative and answered questions. L.T.S. and an older sibling of A.A. were diagnosed with attention deficit disorder/attention deficit hyperactivity disorder (ADD/ADHD) and bipolar and were put on drugs for both. They found cannabis more effective.
>
> 10. Respondent did not observe the boy having a temper tantrum or uncontrollable behavior, but he did not attempt to contact the school or obtain further information from the school. He did not seek to obtain other medical records for the boy. He did not refer the boy to a pediatrician, psychiatrist or pediatric psychiatrist. Instead, after a twenty to thirty-minute interview with the child and his father, Respondent documented a diagnosis for the boy as a "probable combination of ADD/ADHD or bipolar." Respondent did not document any of the criteria for the attention deficit hyper activity disorder or bipolar disorder.
>
> 11. Respondent documented the plan to "try cannabis in small amounts in cookies." He later indicated he would let L.T.S. determine the dosage to be given to the boy. Respondent signed a letter that day stating that A.A. is under his medical care and that A.A. reports that

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[1] Ellipses indicate an allegation not admitted, or in the case of the second footnote, omission of extraneous material.

[2] "Respondent indicates that he began practicing nutritional medicine around 1990 and his practice evolved to recommending marijuana for medical purposes around 1997. He has not had privileges at any hospitals or institutions. He is not a specialist in psychiatry, pediatrics, or pediatric psychiatry."

[3] "The child and his father are identified by random initials to protect their privacy. . . ."

cannabis relieves his medical symptoms. In the letter, Respondent indicates that he recommends/approves of his patient's use of cannabis pursuant to the Compassionate Use Act. He indicates he will continue to monitor A.A.'s condition and provide advice on his progress. It indicates that the recommendation letter is valid for one year. Respondent did not try or recommend any standard treatments for ADHD or bipolar disorder, either psychological or psychopharmacological.

12. Respondent's medical records are four pages long and reference the initial appointment described above, two telephone conversation and to in-person visits with the final date of February 15, 2015. . . .

(Ex. 1, pp. 3-4.)

*Other Findings Pertaining to the Diagnosis and Recommendation, and Subsequent Events*

7. (A) The child's father testified that he was motivated to obtain marijuana for his child because of his personal experience with drugs given to him as a child for ADHD or Bipolar Disorder, and his experience with treatment for such conditions of his older child, mentioned above. Father testified that as a child, he was diagnosed with ADHD, and various medications were used on him, one after the other, and that they did not ameliorate his condition, and often had negative side effects. He described himself as a human guinea pig, describing how various medications were tried, and their dosage manipulated, and when they were not efficacious, a new drug would be tried, with the same results: manipulation of dosage, negative side effects, little benefit to L.T.

(B) L.T. testified that he did not suffer from Bipolar Disorder, but stated that is what his condition was often called, and that this was the result of misinformation being imported into Dependency Court proceedings.[4]

8. According to father, for many years he was against using any nonprescription drugs or illegal substances, but as an adult was convinced to try medical marijuana, which he obtained from Respondent some ten years ago. He found that it managed his symptoms, and he was convinced of its efficacy. He attested that it calmed him, allowed him to sleep, and that he could get up in the morning and work. He testified that he had exhibited anger towards his wife, but once he used marijuana, his angry behaviors toward his wife ceased.

9. An older son has been also diagnosed with ADHD and Bipolar Disorder. Father testified that none of the standard drugs tried on his older child helped, but when the child was an adolescent Father obtained medical marijuana for him, from Respondent, and it had a positive effect. According to father, the effect was such that in a relatively short period of time, the older boy was going to exit the special education program at his school.

[4] Respondent believed L.T. had Bipolar Disorder because of the types of drugs that had been given to him before he consulted with Respondent.

However, the boy moved out of state with his mother, could not obtain medical marijuana in his new state, and he regressed.

10. Father testified that much of the impetus to seeing Respondent was the behavioral problems his child was having in school. He said that the boy's teacher told him he needed to get the child medicated, or he would be excluded from school.

11. After obtaining the medical marijuana medication from Respondent, Father was giving small amounts of the cannabis to T.T.in the morning, in the form of a cookie. He testified that it was having a positive effect on reducing poor behavior. He learned that in the afternoon, however, the behavior returned. Father wanted to give T.T. another small amount of the cannabis at lunch, and went to the school nurse to have her administer it. She turned the matter over to the school administration, which in turn led to efforts by the local child protective services and law enforcement to intervene.

12. Father's testimony is that the cannabis he gave T.T. helped manage the child's behavior, and he perceived no negative effects while he was able to provide it. However, due to the efforts of his local child protective services to take custody of his children, his wife took T.T. and the other children out of state, where medical marijuana was not available.

13. Respondent, after providing the recommendation to L.T., contacted him a week later to find out how things were progressing. On September 20, 2012, Respondent was told that the program was going well, and that T.T. "functions normally and correctly!" (Ex. 22, p. 4 of 5.) On October 12, 2012, Respondent learned of the school's negative reaction to the use of cannabis, that there were efforts by child protective services to take the child and his siblings from L.T. and his wife, and that the mother had left the state with T.T.

14. According to his medical record for T.T., Respondent saw him on September 13, 2013. He learned that there had been a year of problems with child protective services, that the child had not been back to school, and that they had stopped giving him cannabis, because his mother was fearful of more problems with the authorities. According to the chart notes,

> "He [T.T.] is doing relatively well, not in school so demand for drug is not there. PE: 90/60, pulse 95. Mental Status: alert, oriented, calm, smiling. Not talkative. Aware of situation with school and authorities, accepts situation. Diagnosis: ADD/BiPolar."

(Ex. 22, p. 4 of 5.)

15. Respondent's records indicate that another cannabis letter was issued in case the parents decided it was necessary "should behavior exacerbate." (Ex. 22, p. 4 of 5.)

16. It should be noted that the original diagnosis was "probable combination of ADHD/BiPolar." (Ex. 22, p. 3 of 5.) Thus, a year after the first examination of T.T., the

diagnosis had changed from a probable diagnosis to a firmer one, albeit with a different take on attention deficit problems.

17. (A) Respondent saw the child on February 20, 2015. His chart entry states that the child is doing "fairly well." He was not going to a normal school, but not being home schooled, and there was not "pressure to put him on drugs from the outside." (Ex. 22, p. 4 of 5.) His blood pressure was noted as 95/65, with a pulse of 90. His lungs were clear. Mental status was described as "alert, oriented, calm, smiling. Able to participate in conversation normally." (*Id.*)

(B) As with the chart entry for September 13, 2013, the February 20, 2015 entry states a diagnosis of "ADD/BiPolar" and it records that another cannabis letter issued for the child in case the parents decided it was necessary "should behavior exacerbate." (*Ibid.*, p. 5 of 5.)

*The Complaint to the Board*

18. The San Bernardino County Sheriff's Department (Sheriff's) investigated the provision of cannabis to T.T., after learning of it from the school administration. The investigators contacted Respondent in September 2012. He spoke to investigators, and he wrote to them on September 27, 2012. A copy of the letter is found in exhibit 15, p. AGO-40.[5] The investigators generated a written report, which are 103 pages long.

19. On November 14, 2014, Jennifer Burkhart, from the Sheriff's office, emailed the report to Eric Ryan. She noted she had to break the report into four separate e-mails due to its length.

20. Eric Ryan was then an investigator who worked for the Health Quality Enforcement Section of the Department of Consumer Affairs' Division of Investigation. He was stationed in San Diego.

21. Mr. Ryan had, at some time prior to that, been an investigator with the Board. However, in June 2014, the Board's investigators were transferred to the Department of Consumer Affairs' Division of Investigation.

22. Thereafter, Mr. Ryan forwarded Burkhart's e-mail and the accompanying Sheriff's report to the Board's Complaint Unit. It was received there on November 25, 2014.

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[5] This page number refers to a stamped "Bates" number. However, a handwritten number is found on each page of the exhibit, which is different from the stamped number. It appears that the handwritten page numbers paginate the report itself. The stamped numbers paginate the entire exhibit.

23. Receipt of the Sheriff's report triggered an investigation by the Board, which led to this proceeding.

*Respondent's Interview by Board Representatives*

24. On August 7, 2017, Respondent was interviewed by Investigator Tracy Tu and Jill Klessig, M.D., a medical consultant. Respondent's attorney, Mr. Jaffe, accompanied Respondent.

25. During the interview, Respondent stated that the patient's father told him that the child's teacher had, essentially, kicked the child out of school and told the father he couldn't come back unless he was on some drug that would manage the child's behavior. Respondent apparently took the father's claim at face value. This is based on the fact that Dr. Klessig told him that the school told investigating sheriff's that the child was not a problem, which Respondent found "hard to believe."[6] (Ex. 24A, p. 10, lines 9-18.)

26. During his interview Respondent acknowledged that he did not contact the school about the child's behavior. He could not quantify in any way how often the child had tantrums, nor could he describe their duration or the nature of the tantrums; though at one point he said he knew that the tantrums occurred on a regular basis, even more than once per day. (Ex. 24A, p. 13, lines 23-25.) He stated that the parents were able to handle the tantrums in the home, but couldn't say what they were doing, "but they didn't feel the need to give him anything medication-wise." (*Id.*, p. 14, lines17-19.) When pressed later on the nature of the tantrums, Respondent stated he could not remember. (*Id.*, see p. 14, line 20 to p. 16, line 4.)

27. Early in the interview, Respondent stated that T.T. was the only child he had treated for temper tantrums.

28. At one point in the interview Respondent described the child as agitated and nervous, but later stated that "in the office, there wasn't anything that abnormal." (Ex. 24A, p. 21, lines 10-11.)

29. When Respondent was asked how he came to the diagnosis of Bipolar Disorder, he stated he did so based on the history that the father provided. He went on to say that the father and older brother had been diagnosed with Bipolar Disorder, and that the child had "up and down, uh, behaviors that were consistent with it." (Ex. 24A, p. 21, lines 19-20.) However, he could not describe the diagnostic criteria for the malady, except to state that family history is the number one criteria. (*Id.*, lines 23-25.) Respondent claimed he

[6] There is other evidence that Respondent relied on a claim by the parent that the school, or at least the teacher, was demanding action by the parent, and had claimed the child would be excluded. Respondent stated as much in his medical record. (Ex. 22, p. 3.) And, the child's father testified to the effect that the teacher told father he would have to take such steps with his son. (Factual Finding 10.)

reviewed the diagnostic criteria before diagnosing the child as bipolar, though he was vague about when he did so.

30. Respondent was asked what the child's sleep patterns were like, and he could not remember. When pressed about whether he would normally ask about sleep patterns, Respondent first stated that in a rare case such as this one, there is no normal, implying that there was no normal course to follow. But, he then said he would have asked about sleep patterns. (Ex. 24A, p. 23, lines 15-20.) However, no entry in the child's chart refers to sleep patterns. (See ex. 22.)

31. Respondent was asked why, if the situation with the child was so rare, he did not refer the child to a pediatric psychiatrist. He stated that father was not enthusiastic about psychiatrists, having had bad results for himself and the older brother. He stated he talked to the father about the issue, but that is not set out in the chart. He could not explain why he did not do a referral to at least obtain expertise in making the diagnosis, leaving the issue of the medical response for another day.

32. When asked what other diagnostic criteria he considered (besides ADHD and Bipolar Disorder) he said he didn't really consider anything else, and when asked what was the differential diagnosis for "behavior like this," he said at first that there wasn't one, but then said alternatives could be head trauma, and he could think of no other diagnoses that could account for the child's behavior. (Ex. 24A, p. 26, line 22 though p. 27, line 17.)

33. Respondent, when asked if the cannabis was being recommended to treat the ADHD or bipolar disorder, stated that he was just treating the symptoms. (Ex. 24A, p. 28, lines 1-3.)

34. Respondent stated that the risks to a child when given small amounts of medical marijuana were minimal, that "there's pretty much no risk." (Ex. 24A, p. 29, line 25.) He could cite no authority for that position, and when asked where the American Academy of Pediatricians stood on the issue of giving cannabis to a child, Respondent did not know. (*Id.*, p. 30, lines 23-25.)

*Diagnostic Criteria for ADHD and Bipolar Disorder in 2012*

35. (A) During the hearing, the ALJ gave notice that he would take notice of the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision, commonly known as the DSM-IV-TR. That tome is a standard reference for psychologists, psychiatrists, and other medical professionals. The DSM-IV-TR was superseded by the publication of the DSM-5 in March 2013. That latest iteration made a number of changes to diagnostic categories for a number of mental health conditions. Examples include changing Mental Retardation to Intellectual Disability, adopting the Autism Spectrum Disorder while doing away with the category previously known as Pervasive Developmental Disorders, and relevant to this case, changes in the diagnostic criteria for Bipolar Disorder.

(B) Because the DSM-IV-TR was the reference manual at the time that Respondent diagnosed the child, it will be referenced in this proposed decision, and referenced simply as the DSM. If there is need to refer to the newer version, it will be referenced as the DSM-5.

36. Regarding ADHD, the DSM states that:

> The essential feature of Attention Deficit/Hyperactivity Disorder is a persistent patter of inattention and/or hyperactivity-impulsivity that is more frequently displayed and more severe than is typically observed in individuals of comparable level of development (Criterion A). Some hyperactive-impulse or inattention symptoms that cause impairment must have been present before age 7 years, although many individuals are diagnosed after the symptoms have been present for a number of years, especially in the case of individual with the Predominantly Inattentive Type (Criterion B). Some impairment from the symptoms must be present in at least two settings (e.g., at home and at school or work) (Criterion C). There must be clear evidence of interference with developmentally appropriate social, academic, or occupational functioning (Criterion D). The disturbance does not occur exclusively during the course of a Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorder and is not better accounted for by another mental disorder, (e.g., a Mood Disorder, Anxiety Disorder, Dissociative Disorder, or Personality Disorder) (Criterion E).

(DSM, p. 85.)

37. (A) The diagnostic criteria are lengthy. Criterion A requires findings of six or more symptoms of inattention, and six or more symptoms of hyperactivity and impulsivity; the symptoms are taken from a list of nine possible symptoms for each category. Further, the symptoms must have "persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level." (DSM, p. 92.)

(B) The symptoms of inattention, from which at least six must be found, are as follows:

> (a) often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities
> (b) often has difficulty sustaining attention in tasks or play activities
> (c) often does not seem to listen when spoken to directly
> (d) often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (not due to oppositional behavior or failure to understand instructions)
> (e) often has difficulty organizing tasks and activities
> (f) often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework)

(g) often loses things necessary for tasks or activities (e.g., toys, school assignments, pencils, books, or tools)
(h) is often easily distracted by extraneous stimuli
(i) is often forgetful in daily activities

(DSM, p. 92. Punctuation as in original.)

(C) The list of symptoms pertaining to hyperactivity-impulsivity are as follows:

*Hyperactivity*

(a) often fidgets with hands or feet or squirms in seat
(b) often leaves seat in classroom or in other situations in which remaining seated is expected
(c) often runs about or climbs excessively in situations in which it is inappropriate (in adolescents or adults, may be limited to subjective feelings of restlessness)
(d) often has difficulty playing or engaging in leisure activities quietly
(e) is often "on the go" or often acts as if "driven by a motor"
(f) often talks excessively

*Impulsivity*

(g) often blurts out answers before question have been completed
(h) often has difficulty awaiting turn
(i) often interrupts or intrudes on others (e.g., butts into conversations or games)

(DSM, p. 92. Italics and punctuation as in original.)

(D) If Criterion A is met, the other four criterion (B through E), described in Factual Finding 36, must be met.

(E) There can be more than one pattern of behavior, where inattention may predominate over hyperactivity-impulsivity or vice-versa. In those cases, a subtype should be indicated, based on the predominant symptom pattern for the prior six months. The subtypes are "Combined Type," Predominantly Inattentive Type," and "Predominantly Hyperactive-Impulsive Type." (DSM, p. 87.)

38. The DSM states that ADHD is more common in the first-degree biological relatives of children with ADHD than in the general population. It goes on to say that "considerable evidence attest to the strong influence of genetic factors on levels of hyperactivity, impulsivity, and inattention as measured dimensionally. However, family, school, and peer influences are also crucial in determining the extent of impairments and comorbidity." (DSM, p. 90.)

39. (A) Regarding Bipolar Disorder, it must be noted that the DSM devoted 15 pages to Bipolar I Disorder, and Bipolar II Disorder. Further various behaviors or symptoms, such as a "mixed episode" which are components of the symptoms are defined at other parts of the DSM; their descriptions cover many pages. Some aspects of this mental illness as defined in the DSM will be summarized, in order to avoid a prolix discussion.

(B) At the outset of the chapter pertaining to Bipolar Disorder, it is stated that that there are six separate criteria sets for Bipolar I Disorder: Single Manic Episode, Most Recent Episode Hypomanic, Most Recent Episode Manic, Most Recent Episode Mixed, Most Recent Episode Depressed, and Most Recent Episode Unspecified. The first noted, Single Manic Episode, is used to describe someone who are having a first episode of mania. The other five categories are used to specify the nature of the current or most recent episode in individuals who have had recurrent mood episodes. (DSM, p. 382.)

(C) According to the DSM, the essential feature of Bipolar I disorder is a clinical course characterized by the occurrence of one or more Manic Episodes, or Mixed Episodes. (DSM, p. 382.) Manic Episodes are defined by a distinct period in which there is an abnormally and persistently elevated, expansive, or irritable mood. The period must last for at least a week. Other symptoms accompany the episode, including but not limited to inflated self-esteem, decreased need for sleep, and pressure of speech. (*Id.*, p. 357.) A Mixed Episode is characterized by a period of time, lasting at least one week, in which the criteria are met for both a Manic Episode and a Major Depressive Episode, nearly every day. This mood disturbance is severe enough that it causes marked impairment in occupational functioning or in usual social and personal relationships. (*Id.*, pp. 362, 365.)

(D) The average age of onset for Bipolar I Disorder is 20, for both men and women. (DSM, p. 386.)

40. Bipolar II Disorder has a clinical course that is characterized by the occurrence of one or more Major Depressive Episodes accompanied by at least one Hypomanic Episode. (DSM, p. 392.) As part of the diagnostic criteria, there could never be a Manic Episode or a Mixed Episode. (*Id.*, p. 397.)

*T.T.'s Subsequent Diagnosis of Disruptive Mood Dysregulation Disorder*

41. On December 31, 2016, T.T. was admitted to Del Amo Hospital in Torrance, California. His admission diagnosis was Disruptive Mood Dysregulation Disorder (DMDD). He was discharged on January 3, 2017. He was then in the fourth grade. (Ex. 32, p. 5.)

42. The chief complaint on admission is that the child had been acting out, violently, with younger siblings, intimidating them, punching them, and being defiant and exhibiting rage. He had tried to smother his four-year-old brother during a monitored visitation.

43. DMDD is a Depressive Disorder under the DSM-5. According to Dr. Raiss, a psychiatrist and one of the Board's experts, it came about because too many adolescents were being diagnosed as Bipolar. According to the DSM-5, "the core feature of [DMDD] is chronic, severe persistent irritability." (DSM-5, p. 156.) The DSM-5 confirms that the diagnosis was developed for inclusion in the DSM-5 because of issues with diagnosis of children as being Bipolar: "In fact, [DMDD] was added to the DSM-5 to address the considerable concern about the appropriate classification and treatment of children who present with chronic, persistent irritability relative to children who present with classic (i.e., episodic) bipolar disorder." (DSM-5, p. 157.)

44. Further explanation is provided. The authors of the DSM-5 noted there had been a sharp increase in diagnosis of children as having Bipolar Disorder, and that such appeared to have resulted from clinicians combining two clinical presentations into one category. "That is, both classic, episodic presentations of mania, and non-episodic presentations of irritability have been labeled as bipolar disorder in children." (DSM-5, p. 157.)

45. DMDD must have onset before age 10, and it should not be applied to children younger than six. "Age-related variations also differentiate classic bipolar disorder and [DMDD]. Rates of bipolar disorder generally are very low prior to adolescence [less than one percent], with a steady increase into early adulthood [one to two percent prevalence]." (DSM-5, p. 157.)

*The Standard of Care for Diagnosing Bipolar Disorder or ADHD*

46. (A) Diagnosis of mental health issues for a child require, at least, the physician to review the main complaint, the history of the present illness, history of prior treatment, family history, and the child's developmental history. The physician should conduct a mental status exam. Much of that information would have to come from an adult reporter, such as a parent or guardian.

(B) As to Bipolar Disorder, the physician should review the diagnostic criteria set out in the DSM, and search for symptoms of the type recognized by the DSM as indicators of that malady, such as mood, sleep patterns, disorganized thinking or flight of ideas.

(C) As to diagnosing ADHD, the physician should again be informed by the DSM, and should look for evidence of whether any of the nine symptoms of inattention, and of the nine indicators of hyperactivity/impulsivity exist, and note which ones. Furthermore, one should obtain feedback from teachers, because ADHD must exhibit itself in more than one environment.

47. Dr. Raiss testified credibly that rating scales are available to forward to a teacher to obtain feedback that would inform the diagnostic process.

48. The standard of care required Respondent to refer the subject child patient to a specialist in order to confirm whether the child suffered from Bipolar Disorder.

*Respondent's Diagnosis of Bipolar Disorder and ADHD Did Not Meet the Standard of Care*

49. (A) Respondent's diagnosis, whether "probable" or otherwise, did not comport with the standard of care. There is no evidence whatsoever that he consulted the DSM, virtually the Bible of mental health diagnosis. There is no indication that he sought information about T.T.'s moods, sleep patterns, any depression, or any of what Dr. Raiss referred to as pillars of the diagnosis. As noted by Complainant's other expert, Bridget Briggs, M.D., there was no indication of depression, a core symptom of Bipolar Disorder.

(B) Likewise, Respondent did not look to find any of the symptoms of inattention or hyperactivity or impulsivity, as required by the DSM. Nothing in his chart refers to any of the criteria.

50. Nothing in Respondent's chart notes for the September 2012 visit indicate that the child was then suffering from ADHD or Bipolar Disorder. Tantrums alone, and primarily exhibited in one environment (school), do not support either diagnosis. Indeed, his notes would not support a diagnosis of DMDD either. Being "agitated from the stress of the day in school, coming to the doctor" does not resonate with the diagnostic criteria. (Ex. 22, p. 3 of 5.) Being "agitated" and having "trouble sitting still" hint at ADHD, but could simply hint at a preschooler not happy to have driven many miles to a doctor's appointment.[7]

51. Respondent did not seek the opinion of a specialist to reach the correct diagnosis, and did not recommend such action to the father. As pointed out by Dr. Briggs, failure to seek a specialist in determining if there was ADHD was not so critical, but when it came to Bipolar Disorder, referral to a specialist should have been recommended. It is plain that Respondent, who holds himself out as a consultant, is not a specialist of the type that should be utilized to diagnose Bipolar Disorder in a five-year-old child. Even if the father did not want to pursue the traditional psychopharmacological response to ADHD or Bipolar Disorder, making an accurate diagnosis was crucial; it carries life-long significance.

52. It is clear from his interview with the Board that Respondent had not even a basic understanding of the diagnostic criteria for either ADHD or Bipolar Disorder, and he primarily relied on the family history. Family history is not itself a symptom of either condition, as shown by Factual Findings 35-40. Rather, family history is a factor for consideration in analyzing a patient's symptoms.

53. It is clear from his Board interview that Respondent looked to the family history and used that to make his diagnoses; no differential diagnosis was attempted. He

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[7] The record indicates the family lived in Victorville, while Respondent's office was in Hollywood, a significant drive through Southern California traffic.

appeared ignorant of other possible explanations, medical or otherwise, for the tantrums at school. Given that it was early in the school year, the child's behavior might have been a function of separation anxiety of the type exhibited by young children when they begin school. But, Respondent clearly did not look to simpler explanations. Given that the average age of onset for Bipolar Disorder is 20 year of age, and because Bipolar Disorder occurs prior to adolescence in less than one percent of cases (Factual Finding 45) other explanations for the child's tantrums should have been considered.[8]

54. The subsequent diagnoses pronounced by Respondent in September 2013 and February 2015, of ADD/Bipolar Disorder, and the lack of symptoms shown by T.T. on those dates further discredit the original diagnosis. Each of those diagnoses was erroneous, made through violation of the standard of care. No explanation is given regarding the change of diagnosis from ADHD to ADD, or whether Respondent was just inexact in his notes. That the chart entry shows that the child was doing better, without any treatment, including the use of medicinal marijuana, undercuts the initial diagnosis, as well as those of September 2013 and February 2015. The chart notes from the later visits show there were less symptoms reported than were reported in 2012, and the seeming improvement is tied to not having the stress of school. Neither ADHD nor Bipolar Disorder are caused by stress in one environment; the deleterious effects of either condition are ongoing, though with Bipolar Disorder one should expect a series of days-long "episodes" of manic, hypomanic, or depressive behavior.

*The Recommendation of Medicinal Marijuana for Treatment of T.T.*

55. Complainant asserted that Respondent was grossly negligent when he recommended medical marijuana for T.T., a position supported by her experts. In the main, Dr. Raiss believes it is medical marijuana is not efficacious, not supported by evidentiary analysis. He opined that available literature indicates providing cannabis to a child could be harmful, and that Respondent should have used traditional medications that are prescribed for either ADHD or Bipolar Disorder, such as Ritalin, before recommending medical marijuana. In his report, Dr. Raiss cited studies associating adolescent marijuana use with later schizophrenia. Dr. Briggs, when testifying for Complainant, opined that cannabis simply should not be given to a child, let alone one this young. She was of the opinion that the standard of care required Respondent to use interventions approved and recommended by various boards that certify the training and skills of pediatricians and psychiatrists. She believed that the available literature supported her view that there was an undue risk to the child patient if marijuana was administered to the child due to the perceived ADHD or Bipolar Disorder.

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[8] Dr. Briggs testified that the diagnosis of Bipolar Disorder would be "incredibly uncommon" in a five-year-old child. (Reporter's Transcript, vol. II, p. 98, line 17.) That view is consistent with the statements made by William Murdoch, M.D., to Sheriff's investigators, that the youngest child to be reported to have Bipolar Disorder was a six-year-old on the east coast. (Ex. 15, p. AGO 12.)

56. Respondent's experts differed sharply with Dr. Raiss and Dr. Briggs. Dr. Herganrather, who has recommended medical marijuana in a variety of situations for many years, testified that he has recommended marijuana to children with great success. This includes children with genetic disorders, autism, seizure disorders, mood and behavioral disorders, and cancer. He asserted that the literature available has mostly been produced by the National Institute of Drug Abuse (NIDA), which he asserts is not engaged in research into beneficial use of cannabis, but into its abuse. The studies often looked at heavy users, who may also smoke and drink, confounding analysis of the effect of cannabis on young patients. Dr. Herganrather made a good case that much of the negative medical literature is not especially useful in this case, or in any other. Dr. Herganrather did acknowledged the lack of studies, which are difficult to conduct given federal proscription of marijuana use, that support use in patients, including children.

57. Dr. Scherger, who was Respondent's practice monitor when Respondent was on probation during the period between 2004 to 2009, testified that Respondent did not violate the standard of care by recommending marijuana to T.T. He noted the positive report by Father that ingesting the cannabis-laced cookie had a positive effect on the child's behavior.

58. (A) There was some discussion and disagreement about the importance and relevance of a 2012 report by Meier et. al. which was based on the Dunedin Longitudinal Study. That study was based on a sample that was in turn made up of all births at Dunedin's Queen Mary Hospital between April 1972 and March 1973, and which followed persons in the birth cohort for 38 years. Regarding cannabis use, it was reported by Meier that "'. . . persistent cannabis use was associated with neuropsychological decline broadly across domains of functioning,'" and it was further reported that "'. . . impairment was concentrated among adolescent-onset cannabis users, with more persistent use associated with greater decline.'" (Ex. 41, p. 1.) It should be noted that the issue of "persistent" use was important, as the report also stated that those in the Dunedin study who did not report regular use showed no decline in IQ or neuropsychological performance. (*Id.*, p. 2.)

(B) Respondent pointed to a publication which asserted that socio-economic status could have accounted for the results reported by Meier. The author, Ole Rogeberg, concluded that an alternative confounding model based on time-varying effects of socioeconomic effect on IQ indicated that Meier's likely over-estimated the effects of cannabis use in adolescents and young adults, and the effect could even be zero. While it was asserted that Rogeberg is an economist, and not a medical professional, his analysis was, essentially, focused on Meier's methodology and statistical analysis, and Rogeberg used other statistical methods to come to his conclusions. (See ex. 43.)

59. A study of nearly 70 studies of cannabis users was published by the American Medical Association in June 2018. It is titled "Association of Cannabis With Cognitive Functioning in Adolescents and Young Adults—A Systematic Review and Meta-Analysis" (Ex. 39.) In the section entitled "Conclusions and Relevance," the authors state:

> Associations between cannabis use and cognitive functioning in cross-sectional studies of adolescents and young adults are small and may be of questionable clinical importance for most individuals. Furthermore, abstinence of longer than 72 hours diminishes cognitive deficits associated with cannabis use. Although other outcomes (eg. psychosis) were not examined in the included studies, results indicate that previous studies of cannabis in youth may have overstated the magnitude and persistence of cognitive deficits associated with use. Reported deficits may reflect residual effects from acute use or withdrawal. Future studies should examine individual differences in susceptibility to cannabis-associated cognitive dysfunction.

(Ex. 39, p. 1.)

60. In a sense, the medical literature cannot be said to weigh heavily against use of medical marijuana to treat a child for ADHD or a mood disorder, even if the literature does not weigh heavily in favor of its use. In this case Father, rightly or wrongly, did not want to utilize the typical drugs, due to his own experience as a child, and with his older child. It should be noted that Dr. Raiss explained that a psychiatrist like himself would prescribe one of the drugs in the standard arsenal, and that the dosage would have to be titrated, to assess the effectiveness of the drug. If it did not work well, or had too many side-effects, another medication would be tried. This mirrors the process that Father went through as a child.

Plainly, the standard medical response has no sure fire success, and the side effects of the usual medications may be pernicious.[9]

61. The record shows that Father was knew of his choices in how to respond to T.T.'s condition. For Respondent to recommend a small amount of medical marijuana as first response alone does not violate the Board's written statement regarding the use of medical marijuana (ex. 20); they do not bar cannabis as a first-line response. There would have to be some feedback about the effectiveness of the cannabis (which Father initially provided), and whether more or less should be provided, which process mirrors the process that Dr. Raiss would use with pharmacological agents.

62. It has not been established, by clear and convincing evidence, that the recommendation of medical marijuana to T.T., with his father's consent, violated the standard of care. At bottom, the literature does not drive a finding that he did, and the split opinions of the experts, and Dr. Herganrather's positive experience with providing children with medical marijuana, make the matter less than clear.[10]

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[9] Dr. Klessig, during Respondent's interview by the Board, stated her personal (as opposed to the Board's) opinion that "kids are over-medicated with all that . . . other stuff, too." (Ex. 24A, p. 41, lines 8-10.)

[10] During cross examination, Dr. Raiss was asked if he agreed with the allegation, in the Accusation, to the effect that "there is evidence of adverse effects of marijuana on the age

*The Medical Records Are Adequate*

63. It was alleged, as Fourth Cause for Discipline, that Respondent was subject to discipline for failure to maintain adequate and accurate records. The allegation is based on the allegations set out in paragraphs 9 through 12 of the Accusation, a part of which are admitted by Respondent.

64. While the records do not support the diagnosis, they do set out a history, results of some physical examination, a diagnosis, and a plan to deal with the perceived problem.

65. Dr. Raiss in his report did not address Respondent's records. He did not provide testimony about the chart, from a record-keeping perspective. Neither did Dr. Briggs. On the other hand, Dr. Scherger, who had served as Respondent's practice monitor, opined that during that period he would have considered the records, as written, to be accurate.

66. The weight of the evidence does not support the allegation that Respondent failed to make and keep accurate and adequate medical records.

*Respondent's Disciplinary History*

67. On May 24, 2002, an ex parte Interim Order of Suspension (also known as an Interim Suspension Order or ISO) was issued against Respondent. That ISO was issued based on findings that Respondent had, in four cases, issued recommendations that people who were ostensibly his patients use medicinal marijuana. In fact, each of the four persons were undercover investigators. The evidence was that these four individuals did not have serious or substantial medical problem, that Respondent did not examine them, and Respondent had no reasonable basis for making any treatment recommendations.

68. On October 1, 2002, a noticed hearing on the petition for ISO occurred. It involved the same factual issues that were at issue in the ex parte ISO proceeding, that is, Respondent's issuance of recommendations for medical marijuana to four undercover operators. On October 9, 2002, the petition was granted, and Respondent's certificate was suspended pending the outcome of a disciplinary proceeding then pending against Respondent.

69. Prior to the time of the ex parte Petition for ISO, Complainant's predecessor had filed an Accusation against Respondent, seeking to discipline his certificate. That proceeding was initiated on July 13, 2001. That proceeding, *In the Matter of the Accusation*

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group . . . [of] a 4 year old just about to turn five." He testified that the statement is not accurate. He then discussed that the available literature had looked at adolescents, but had not looked at children either smoking or using marijuana. (Reporter's Transcript, vol. I, p. 125, line 23 to p.126, line 5.)

*Against William s. Eidelman, M.D.*, case no. 06-2000-108619, OAH case no. 2000080183, alleged that Respondent, had provided medical marijuana recommendations without a good faith examination, without adequate follow-up, and failing to keep adequate records. Further, it was alleged that Respondent aided and abetted the unlicensed practice of medicine.

70. Subsequently, a First Amended and a Second Amended Accusation were filed against Respondent. The effect of the amendments, generally, was to add allegations pertaining to other patients, either actual or undercover investigators posing as patients.

71. (A) A hearing was held before H. Stuart Waxman, ALJ, on several days in February 2004, and on one day in April of that year. On May 21, 2004, ALJ Waxman issued his proposed decision, which was adopted by the Board and made effective on July 6, 2004.

(B) In a lengthy and detailed decision, ALJ Waxman found numerous departures from the standard of care. He concluded that cause was established to discipline Respondent's certificate for gross negligence, repeated negligent acts, incompetence, furnishing dangerous drugs without a good faith examination, dishonesty and false representations, aiding and abetting the unlicensed practice of medicine, failure to maintain adequate records, and for using a fictitious business name without approval.
Judge Waxman rejected a number of Respondent's defenses, including that he had immunity based on the Compassionate Use Act.[11]

(C) Notwithstanding these serious violations, Respondent's certificate was placed on probation for five years, subject to a number of conditions, including that Respondent's practice be monitored, and that he attend a recordkeeping course.

72. On February 20, 2007, Complainant's predecessor filed an Accusation and Petition to Revoke Probation against Respondent, in case number D1-2000-108619, OAH number 200050035. A hearing in that matter took place in June 2009 before ALJ Samuel D. Reyes.

73. (A) ALJ Reyes found that in connection with one patient, Respondent had engaged in repeated negligent acts, and that he had failed to maintain adequate records. However, it was noted that at around the time of his examination and treatment of the patient, Respondent, with the help of his practice monitor, continued his then-ongoing efforts to improve his recordkeeping practices, which efforts had been underway since Respondent had

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[11] In one instance, an undercover officer saw Respondent purporting to be a new patient. The officer did not claim a serious medical condition. Respondent asked if the "patient" was in pain, and the latter said after workouts. Respondent asked if the patient was depressed, and the latter said he was not. "Respondent then asked if [patient] would get depressed if he did not have marijuana, and [patient] answered affirmatively. Respondent then provided [patient] with a recommendation letter for medical marijuana." (Ex. 10, p. 18, Factual Finding 56.)

completed his record keeping class. Therefore, probation was not revoked; rather, Respondent's license was reproved.

(B) The Board adopted the proposed decision issued by ALJ Reyes on September 9, 2009, the adoption order being effective October 5 of that year.

74. On October 30, 2009, the Board ordered Respondent's certificate fully restored, effective October 6, 2009. Since that time, this matter is the only one brought against Respondent.

## LEGAL CONCLUSIONS

*General Principles Applied In This Case*

1. (A) The standard (as opposed to the burden) of proof applicable to the Complainant in this proceeding was that of clear and convincing evidence, to a reasonable certainty. *(Eittinger v. Bd. of Med. Quality Assurance* (1982) 135 Cal.App.3d 853.) Complainant was obligated to adduce evidence that was clear, explicit, and unequivocal—so clear as to leave no substantial doubt and sufficiently strong as to command the unhesitating assent of every reasonable mind. (*In Re Marriage of Weaver* (1990) 224 Cal.App.3d 278.)

(B) On the other hand, where Respondent was burdened with proving some defense, such as the bar of the statute of limitations, he was required only to prove the factual basis of such by a preponderance of the evidence. (Evidence Code, sections 500 and 115.)

2. A professional is negligent if he or she fails to use that reasonable degree of skill, care, and knowledge ordinarily possessed and exercised by members of the profession under similar circumstances, at or about the time of the incidents in question. Just what that standard of care is for a given professional is a question of fact, and in most circumstances must be proven through expert witnesses. *(Flowers v. Torrance Memorial Hospital Medical Center* (1994) 8 Cal.4th 992, 997-998, 1001; *Alef v. Alta Bates Hospital* (1992) 5 Cal.App. 4th 208, 215; *see* 6 B. Witkin, *Summary of California Law* (9th Ed.), *Torts*, sections 749, 750, and 774.) However, in some cases the standard may be defined by a statute or regulation.

3. The Business and Professions Code[12] does not define what "gross negligence" means in proceedings of this type. However, the Court of Appeal addressed this matter in *Kearl v. Board of Medical Quality Assurance,* (1986) 189 Cal.App.3d 1040. There the Second District Court of Appeal stated:

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[12] All statutory references shall be to the Business and Professions Code unless otherwise noted.

> Gross negligence is "'the want of even scant care or an extreme departure from the ordinary standard of conduct.'" (*Cooper v. Board of Medical Examiners* (1975) 49 Cal.App.3d 931, 941 [123 Cal.Rptr.[page 1053], quoting from *Van Meter v. Bent Construction Co.* (1956) 46 Cal.2d 588, 594 [297 Cal.Rptr. 644].) The use of the disjunctive in the definition indicates alternative elements of gross negligence—both need not be present before gross negligence will be found. (*Gore v. Board of Medical Quality Assurance* (1980) 110 Cal.App.3d 184, 196-197 [167 Cal.Rptr. 881].)[13]

(189 Cal.App.3d at 1052-53.)

4. The terms "negligent" and "incompetent" are not synonymous. (*Pollak v. Kinder* (1978) 85 Cal.App.3d 833, 838.) "[A] licensee may be competent or capable of performing a given duty but negligent in performing that duty." (*Ibid.*) While *Pollak* involved a single act of negligence by an insurance broker, as opposed to repeated negligent acts, and incompetence was not found, the Court made clear that incompetence may be found where a licensee demonstrates a "general lack of present ability to perform a given duty". (*Pollack, supra*, 85 Cal.App.3d at 837; *see also James v. Bd. of Dental Examiners* (1985) 172 Cal.App.3d 1096, at 1109: "Incompetence generally is defined as a lack of knowledge or ability in the discharging of professional obligations. Often, incompetency results from a correctable fault or defect.")

5. (A) Complainant has alleged general unprofessional conduct by Respondent. That term has been defined in *Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564. There the Medical Board initiated disciplinary proceedings against a physician for "unprofessional conduct" without specifying any particular subsection of the enabling statute. That statute, former section 2361, then stated that "unprofessional conduct includes, but is not limited to" various acts enumerated thereafter in the statute. (81 Cal.App.3d at 575.)

(B) The Court of Appeal held that while an overly broad connotation cannot be given to the term "unprofessional conduct," and that it must relate to conduct indicating an unfitness to practice, the meaning was not confined to those matters specifically set forth in the statute. Instead, "[un]professional conduct is that conduct which breaches the rules or ethical code of a profession, or conduct which is unbecoming a member in good standing of a profession." (81 Cal.App.3d at 575.)

6. (A) It is settled that the trier of fact may "accept part of the testimony of a witness and reject another part even though the latter contradicts the part accepted." (*Stevens v. Parke Davis & Co.* (1973) 9 Cal.3d 51, 67.) The trier of fact may also "reject part of the testimony of a witness, though not directly contradicted, and combine the accepted portions with bits of testimony or inferences from the testimony of other witnesses thus weaving a

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[13] The disjunctive definition set forth in *Gore* was also followed in *Yellen v. Bd. of Med. Quality Assurance* (1985) 174 Cal.App.3d 1040, 1058

cloth of truth out of selected material." (*Id.*, at 67-68, quoting from *Neverov v. Caldwell* (1958) 161 Cal.App.2d 762, 767.) Further, the fact finder may reject the testimony of a witness, even an expert, although not contradicted. (*Foreman & Clark Corp. v. Fallon* (1971) 3 Cal.3d 875, 890.) And, the testimony of "one credible witness may constitute substantial evidence", including a single expert witness. (*Kearl v. Board of Medical Quality Assurance, supra*, 189 Cal.App.3d at 1052.)

(B) The rejection of testimony does not create evidence contrary to that which is deemed untrustworthy. Disbelief does not create affirmative evidence to the contrary of that which is discarded. The fact that a trier of fact may disbelieve the testimony of a witness who testifies to the negative of an issue does not of itself furnish any evidence in support of the affirmative of that issue, and does not warrant a finding in the affirmative thereof unless there is other evidence in the case to support such affirmative. (*Hutchinson v. Contractors' State License Bd* (1956) 143 Cal.App.2d 628, 632-633, quoting *Marovich v. Central California Traction Co.* 191 Cal.295, 304.)

(C) As stated by the Court of Appeal in *Meiner v. Ford Motor Co.*, (1971) 17 Cal.App.3d 127, 140, "On the cold record a witness may be clear, concise, direct, unimpeached, uncontradicted -- but on a face to face evaluation, so exude insincerity as to render his credibility factor nil. Another witness may fumble, bumble, be unsure, uncertain, contradict himself, and on the basis of a written transcript be hardly worthy of belief. But one who sees, hears and observes him may be convinced of his honesty, his integrity, his reliability." In this case the undersigned has considered such factors in assessing the credibility of witnesses.

*Legal Conclusions Dispositive of the Case*

7. The legislature promulgated a statute of limitations that governs the Board's disciplinary actions; it is found at section 2230.5. Section 2230.5, subdivision (a), provides in pertinent part:

> Except as provided in subdivisions (b), (c), and (e), any accusation filed against a licensee pursuant to Section 11503 of the Government Code shall be filed within three years after the board, or a division thereof, discovers the act or omission alleged as the ground for the disciplinary action, or within seven years after the act or omission alleged as the ground for disciplinary action occurs, whichever occurs first.

8. (A) The Board adopted a regulation to be used in interpreting section 2230.5. That regulation is found at California Code of Regulations (CCR), title 16, section 1356.2.[14] CCR section 1356.2, subdivision (a) states in pertinent part:

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[14] Further citations to the CCR shall be to title 16 thereof.

For purposes of Section 2230.5 of the code, the word "discovers" means, with respect to each act or omission alleged as the ground for disciplinary action:

(1) The date the board received a complaint or report describing the act or omission.

(B) Subdivision (b)(1) defines "complaint" as a "written complaint from the public or a written complaint generated by board staff that names a particular physician." Subdivision (b)(2) defines a "report" as "any written report required under the code to be filed with the board but does not include a notice filed under CCR sec. 364.1."

9. The receipt of the Sheriff's investigation report at the Department's Division of Investigation was not the receipt of that document by the Board. From the record it is clear that the Division of Investigation, although it provides investigation services for the Board, is a separate organization. The Division of Investigation in turn has a separate unit, the Health Quality Investigation Unit, which serves not only the Board, but several other agencies that license health care providers, such as the Board of Podiatric Medicine and the Board of Psychology. (§ 159.5, subd. (b)(1). See also, § 160.5,subd. (b).) The report was received at the Board's Complaint Unit on November 25, 2014, leaving the statute of limitations open until November 25, 2017. The filing of the Accusation herein was within the statute of limitations. (Factual Findings 5, 18-23.)

10. (A) Respondent asserts that he is immune from Board action pursuant to Health and Safety Code section 11362.5, subdivision (c), which states that "notwithstanding any other provision of law, no physician in this state shall be punished, or denied any right or privilege, for having recommended marijuana for medical purposes. He made the same claims to Judge Waxman and Judge Reyes, and failed in each case, as he must here.

(B) First of all, the Board adopted a precedential decision that pertains to this issue, after the first proceeding against Respondent, and before the second. (*In the Matter of the Accusation Against Tod H. Mikuriya,* M.D. (2007) Precedential Decision No. MBC-2007-02Q.) As noted by Judge Reyes, the Board concluded that the immunity is qualified, and that it does not exempt a physician from standards or regulations generally applicable to physicians, including those that govern the manner or process by which the physician's recommendation was reached. (Ex. 12, p. 17-18.)

(C) Judge Waxman had reached similar conclusion, pointing out that Respondent was not being disciplined because he recommended marijuana for medical purposes, but for a variety of other reasons relating to the methods he followed in arriving at the recommendation. (Ex. 10, p. 46.)

(D) The same reasoning applies here. Respondent made a diagnosis without adequate basis, and without adequate research and study. He is not immunized for making a diagnosis that was grossly negligent. The immunity defense fails.

11. Respondent's certificate is subject to discipline pursuant to section 2234, subdivision (b), for gross negligence in his care and treatment of T.T., by diagnosing him with ADHD and Bipolar Disorder, based on Legal Conclusions 1 through 3, and Factual Findings 1 through 54.

12. It was established that Respondent is subject to discipline for repeated negligent acts pursuant to section 2234, subdivision (c), in connection with his care and treatment of T.T., in that he made erroneous diagnoses of the child on three occasions, in September 2012 and 2013, and February 2015. This Conclusion is based on Legal Conclusions 1 and 2, and Factual Findings 1 through 54.

13. Respondent's certificate is subject to discipline for incompetence pursuant to section 2234, subdivision (d), for his care and treatment of T.T., based on Legal Conclusions 1, 2, and 4, and Factual Findings 1 through 54. He demonstrated ignorance of the diagnostic criteria for ADHD and Bipolar Disorder, and in how those disorders should be diagnosed, and he failed to recommend assessment of the child by a qualified specialist, among other things.

14. It was not established that Respondent's certificate should be disciplined pursuant to section 2266 for failing to maintain adequate and accurate records, based on Factual Findings 63 through 66.

15. Respondent's certificate is subject to discipline for general unprofessional conduct pursuant to section 2234, though his care and treatment of T.T., based on Legal Conclusions 1, 2, and 5, and Factual Findings 1 through 54.

16. Allegations or claims upon which findings or conclusions are not made are deemed unproven, or surplusage.

17. (A) Under the Board's Disciplinary Guidelines, Respondent is subject to an order ranging from revocation stayed, with probation, through revocation. This is Respondent's third disciplinary proceeding. Although he did not outright suggest a diagnosis that would justify a marijuana recommendation, as he did in his first proceeding (see Factual Finding 71), he all but made one up out of whole cloth, having no real knowledge of the diagnostic criteria, or proper diagnostic process, to determine if a child is suffering from either ADHD or Bipolar Disorder. His stated reliance on family history alone indicates incompetence.

(B) It was not established that the child was harmed by Respondent's actions, but Complainant need not establish that harm occurred. (*Kearl v. Board of Medical Quality Assurance* (1986) 189 Cal.App.3d 1040, 1053.) There was significant threat of harm in this case. Dr. Briggs pointed out that labelling a child with a significant mental condition can be harmful, and this resonates with the ALJ, who has held several hundred hearings or mediations for 10 of the state's 21 regional centers, and for schools in the special education

context.[15] Diagnostic labels can follow the child for life, and if those labels are incorrect, pernicious results may follow. In any event, proper diagnosis is the foundation of any subsequent medical action, and Respondent made little or no effort to acquaint himself with the then-prevailing diagnostic criteria.

(C) To be sure, not all of the claims have been proven against Respondent. It appears reasonable minds can, and did, differ over whether or not cannabis should be given in low amounts to a child who suffered from ADHD or Bipolar Disorder, as Respondent concluded. However, before such a step was taken, a proper diagnosis should have been made, and Respondent, through ignorance and neglect, failed to make a proper diagnosis.

(D) The purpose of hearings of this type is to protect the public, and not to punish an errant practitioner. (*Hughes v. Board of Architectural Examiners* (1998) 17 Cal.4th 763, 784-786; *Bryce v. Board of Medical Quality Assurance* (1986) 184 Cal.App.3d 1471, 1476.) At the same time, public protection is the Board's highest priority. (§ 2229.) Respondent has had two opportunities to consider his practice methods and their shortcomings, and he has not learned from those cases. Public protection requires the revocation of Respondent's certificate.

## ORDER

The Physician's and Surgeon's certificate issued to Respondent William S. Eidelman, M.D., number G 32011, is hereby revoked.

DATED: November 6, 2018

DocuSigned by:
Joseph D. Montoya
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JOSEPH D. MONTOYA
Administrative Law Judge
Office of Administrative Hearings

[15] The regional centers provide services to the developmentally disabled pursuant to the Lanterman Developmental Disabilities Services Act (Lanterman Act), California Welfare and Institutions Code, section 4500, et seq. While ADHD is not an eligible condition for regional center services, whether a child has or does not have that condition is often an issue, and hence the ALJ had a passing familiarity with it. This is relevant because the ALJ may evaluate evidence based on his experience and training. (Govt. Code, § 11425.50, subd. (c).)

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**BEFORE THE**
**MEDICAL BOARD OF CALIFORNIA**
**DEPARTMENT OF CONSUMER AFFAIRS**
**STATE OF CALIFORNIA**

| | |
|---|---|
| In the Matter of the Accusation Against:<br><br>**William S. Eidelman, M.D.**<br>**1654 N. Cahuenga Blvd.**<br>**Los Angeles, California 90028**<br><br>**Physician's and Surgeon's Certificate No. G 32011,**<br><br>Respondent. | Case No. 800-2014-010147<br><br>**ACCUSATION** |

Complainant alleges:

## PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about July 1, 1976, the Medical Board issued Physician's and Surgeon's Certificate Number G 32011 to William S. Eidelman, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on February 28, 2019, unless renewed.

## JURISDICTION

3. This Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Board deems proper.

5. Section 2234 of the Code, states:

"The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

"(d) Incompetence.

"(e) The commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

"(f) Any action or conduct which would have warranted the denial of a certificate.

"(g) The practice of medicine from this state into another state or country without meeting the legal requirements of that state or country for the practice of medicine. Section 2314 shall not apply to this subdivision. This subdivision shall become operative upon the implementation of the

proposed registration program described in Section 2052.5.

"(h) The repeated failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board."

6. Section 2262 of the Code states:

AAltering or modifying the medical record of any person, with fraudulent intent, or creating any false medical record, with fraudulent intent, constitutes unprofessional conduct.

AIn addition to any other disciplinary action, the Division of Medical Quality[1] or the California Board of Podiatric Medicine may impose a civil penalty of five hundred dollars ($500) for a violation of this section."

7. Section 2266 of the Code states: "The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

**FIRST CAUSE FOR DISCIPLINE**

**(Gross Negligence)**

8. Respondent is subject to disciplinary action under section 2234, subdivision (b), in that he was grossly negligent in the care and treatment of patient A.A. The circumstances are as follows:

9. On or about September 13, 2012, Respondent[2] had an appointment with a four-year-old boy, A.A.[3] During the appointment, the boy and his father, L.T.S., were in the room. Respondent talked with each of them at various times for a total of approximately 20 minutes. Respondent had treated L.T.S. in the past and provided him recommendations for marijuana for medical purposes. The chief complaint for the child was that he had episodes of uncontrollable

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[1] References to the Division of Medical Quality is deemed by Business and Professions Code section 2002 to refer to the Board.

[2] Respondent indicates that he began practicing nutritional medicine around 1990 and his practice evolved to recommending marijuana for medical purposes around 1997. He has not had privileges at any hospitals or institutions. He is not a specialist in psychiatry, pediatrics or pediatric psychiatry.

[3] The child and his father are identified by random initials to protect their privacy. Respondent will be provided notice of their identities during discovery.

behavior and temper tantrums. Respondent primarily spoke with L.T.S. during the appointment. Respondent noted that the boy was normal appearing, agitated from the stress of the day in school, coming to the doctor, alert, oriented, appropriate, but agitated, and having trouble sitting still. No looseness of association was noted. He was not talkative and answered questions. L.T.S. and an older sibling of A.A. were diagnosed with attention deficit disorder/attention deficit hyperactivity disorder (ADD/ADHD) and bipolar and were put on drugs for both. They found cannabis more effective.

10. Respondent did not observe the boy having a temper tantrum or uncontrollable behavior, but he did not attempt to contact the school or obtain further information from the school. He did not seek to obtain other medical records of the boy. He did not refer the boy to a pediatrician, psychiatrist or pediatric psychiatrist. Instead, after the twenty to thirty-minute interview with the child and his father, Respondent documented a diagnosis for the boy as a "probable combination of ADD/ADHD or bipolar." Respondent did not document how A.A. met any of the criteria for the attention deficit hyperactivity disorder or bipolar disorder.

11. Respondent documented the plan to "try cannabis in small amounts in cookies." He later indicated that he would let L.T.S. determine the dosage to be given to the boy. Respondent signed a letter that day stating that A.A. is under his medical care and that A.A. reports that cannabis relieves his medical symptoms. In the letter, Respondent indicates that he recommends/approves of his patient's use of cannabis pursuant to the Compassionate Use Act. He indicates he will continue to monitor A.A.'s condition and provide advice on his progress. It indicates that the recommendation letter is valid for one year. Respondent did not try or recommend any standard treatments for ADHD or bipolar disorder, either psychological or psychopharmacological.

12. Respondent's medical records are four pages long and reference the initial appointment described above, two telephone conversations and two in-person visits with a final date of February 20, 2015. Respondent subsequently indicated a lack of familiarity with any peer-reviewed scientific literature regarding the side effects of cannabis use in children and adolescents under the age of 18 years old.

13. Respondent committed gross negligence in his care and treatment of patient A.A. when he diagnosed A.A. with ADD/ADHD and bipolar disorder based on nothing more than a twenty to thirty-minute interview of the child and his father.

14. Respondent committed gross negligence in his care and treatment of patient A.A. when he recommended cannabis as a first-line treatment of ADD/ADHD and bipolar disorder despite evidence of adverse effects of marijuana on the age group.

**SECOND CAUSE FOR DISCIPLINE**

**(Repeated Negligent Acts)**

15. Respondent is subject to disciplinary action under section 2234, subdivision (c), in that he was negligent in his care and treatment of patient A.A. The circumstances are as follows:

16. Paragraphs 9 through 12 are incorporated here as if set forth in full.

17. Respondent committed negligence in his care and treatment of patient A.A. when he diagnosed A.A. with ADD/ADHD and bipolar disorder based on nothing more than a twenty to thirty-minute interview of the child and his father.

18. Respondent committed negligence in his care and treatment of patient A.A. when he recommended cannabis as a first-line treatment of ADD/ADHD and bipolar disorder despite evidence of adverse effects of marijuana on the age group.

**THIRD CAUSE FOR DISCIPLINE**

**(Incompetence)**

19. Respondent is subject to disciplinary action under section 2234, subdivision (d), in that he demonstrated incompetence in his care and treatment of patient A.A. and his discussion of same on a subsequent date. The circumstances are as follows:

20. Paragraphs 9 through 12 are incorporated here as if set forth in full.

**FOURTH CAUSE FOR DISCIPLINE**

**(Failure to Maintain Adequate and Accurate Medical Records)**

21. Respondent is subject to disciplinary action under section 2266 in that he failed to maintain adequate and accurate records pertaining to his care and treatment of patient A.A. The circumstances are as follows:

22. Paragraphs 9 through 12 are incorporated herein as if fully set forth.

**FIFTH CAUSE FOR DISCIPLINE**

**(General Unprofessional Conduct)**

23. Respondent is subject to disciplinary action under section 2234 in that he committed general unprofessional conduct in his care and treatment of patient A.A. The circumstances are as follows:

24. Paragraphs 8 through 22 are incorporated herein as if fully set forth.

**DISCIPLINARY CONSIDERATIONS**

25. To determine the degree of discipline, if any, to be imposed on Respondent, Complainant alleges that on or about May 24, 2002, an Ex Parte Interim Order of Suspension was issued in a matter entitled *In the Matter of the Petition for Interim Suspension Order Against William S. Eidelman, M.D.*, Case No. 06-2000–108619, due to the risk that Respondent's continued practice of medicine would endanger the public health, safety or welfare. The Order found that in four instances, Respondent had recommended treatment to patients without first obtaining an adequate history, conducting an adequate clinical exam or testing and without obtaining any reliable objective information regarding the patients' medical status. Further, his office lacked even basic medical assessment tools or equipment with which to assess a patient.

26. On or about October 9, 2002, an Interim Order of Suspension was issued in a matter entitled *In the Matter of the Petition for Interim Suspension Order Against William S. Eidelman, M.D.*, Case No. 06-2000–108619, due to the continuing risk that Respondent's practice of medicine would endanger the public health, safety or welfare. The Order made similar findings to the prior Ex Parte Interim Suspension Order issued earlier in the year.

27. On or about June 3, 2004, effective on July 6, 2004, in a prior disciplinary action entitled *In the Matter of the Accusation Against William S. Eidelman, M.D.*, before the Medical Board of California, following a hearing, good cause was found to discipline Respondent's license related to his issuance of recommendations for marijuana for medical purposes.[4] As a

[4] Specifically, he was found to have committed gross negligence and repeated negligent acts by disregarding his duty to diagnose and treat on the basis of a proper history, examination

result, Respondent's license was revoked, the revocation was stayed and Respondent was placed on five (5) years of probation on numerous terms and conditions including: (1) having a practice monitor or participating in a professional enhancement program that includes regular chart review, practice assessment, professional growth and education; (2) successfully completing a course in medical record keeping; and (3) successfully completing within six months from the effective date of the decision a clinical training or education program equivalent to the Physician Assessment and Clinical Education Program (PACE) offered at the University of California – San Diego School of Medicine. Respondent completed the probation effective October 6, 2009.

28. Following a hearing, effective on October 5, 2009, in a prior disciplinary action entitled *In the Matter of the Accusation and Petition to Revoke Probation Against William S. Eidelman, M.D.*, File No. D1-2000-108619, before the Medical Board of California, the Board found cause to exist to discipline Respondent's license for repeated acts of negligence and failure to maintain adequate and accurate medical records in care and treatment of a patient to whom he recommended marijuana in 2001 and 2005. The Board imposed discipline in the form of public reproval pursuant to Business and Professions Code sections 495 and 2227, subdivision (a)(4).

**PRAYER**

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number G 32011, issued to William S. Eidelman, M.D.;

2. Revoking; suspending or denying approval of William S. Eidelman, M.D.'s authority to supervise physician assistants and advanced practice nurses;

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and review of symptoms, sometimes failing to perform any physical exam at all, essentially placing decisions of diagnosis and treatment in his patients' hands. In several, histories obtained were limited to patients' explanation of why they sought recommendations marijuana for medical purposes. Also, Respondent failed to medically address patients' complaints that were not treatable with marijuana and he failed to establish and follow a plan for follow-up. Additionally, he was found to have made dishonest and false representations; to have aided and abetted the unlicensed practice of medicine, allowing an unlicensed individual to maintain and use a pad of his pre-signed prescription forms; and failing to maintain adequate and accurate records. Last, Respondent was found to be incompetent by failing to understand the necessity of taking a proper history, conducting a physical examination, correctly charting a patient's history, subjective findings, objective findings, assessment, treatment plan, follow up and the like.

3. Ordering William S. Eidelman, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

4. Taking such other and further action as deemed necessary and proper.

DATED: November 22, 2017

Christine L. Kelly for Kimberly Kirchmeyer

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
*Complainant*

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